Department of Health and Human Services
Health Care Financing Administration
Operational Policy Letter #99.078
OPL99.078

Date: January 25, 1999

Subject: Reporting Requirements for Medicare Managed Care Organizations in 1999: Health Plan Employer Data and Information Set (HEDIS® 1999) Measures that Include the Medicare Health Outcomes Survey (HOS) [Formerly the Health of Seniors Survey] and the Medicare Consumer Assessment of Health Plans Study (CAHPS™ 2.0H)

Important Changes from 1998

This OPL provides information regarding the 1999 Medicare HEDIS submission and provides clarification for Medicare contracting organizations that are converting to Medicare +Choice (M+C), those who are not converting and those organizations that are terminating their contracts or are non-renewing parts of their service areas. Since this OPL covers a year of transition from Section 1876 to Balanced Budget Act provisions, it contains terms relating to both programs. The following changes are also noted:

- HCFA will not require MCOs to report HEDIS 1999 data if the MCO's first Medicare enrollment occurred on February 1, 1998 or later. (See I.C.6)

- HCFA will administer CAHPS in the Fall of 1999. (See IV.B)

- HCFA requires submission of both summary and patient-level HEDIS data on June 30, 1999. (See II.A.)

- HCFA will not pay for or arrange for the Medicare HEDIS audit. Medicare Managed Care Organizations (MCOs) must contract with an NCQA-licensed, HEDIS audit organization to conduct the audit of their Medicare data and the site visit team must be led by an NCQA certified HEDIS Compliance Auditor. (See II.B.2)

- The Medicare audit for 1999 will audit nine measures on site. Similar to last year, HCFA will require a partial NCQA Compliance audit. HCFA may present a subset of these measures to beneficiaries through its *Medicare Compare* Internet site and *Medicare & You* handbook. (See II.B.1 and Attachment III)

- MCOs will receive only one Detail Report from NCQA, for informational purposes only, after NCQA has uploaded the submission into its database. In previous years MCOs have

received two reports. As always, MCOs may not change their data after the submission date. (See II.A.1)

- The Health of Seniors Survey has been renamed the Medicare Health Outcomes Survey (HOS).

Background

Effective January 1, 1997, HCFA began requiring MCOs to report on performance measures from the HEDIS reporting set relevant to the Medicare managed care population, and to participate both in CAHPS and the HOS survey-based HEDIS measure. This OPL explains 1999 reporting requirements for HEDIS 1999, HOS, and CAHPS and addresses specific HCFA requirements regarding how health plans must implement HEDIS 1999, HOS, and CAHPS.

These requirements are consistent with HCFA's regulatory/statutory authority and contract terms with health plans to obtain the information necessary for proper oversight of the program. It is critical to HCFA's mission that we collect and disseminate information that will help beneficiaries choose among health plans, contribute to better health care through identification of quality improvement opportunities, and assist HCFA in carrying out its responsibilities.

HCFA will make summary, plan-level performance measures available to the public through media that is beneficiary oriented, such as the *Medicare Compare* Internet site and the *Medicare & You* handbook. A subset of HEDIS and CAHPS data will also be available in printed form through a toll free line. Additionally, information may be released at a more technical level, such as releasing raw HEDIS data and the results of research using these data.

Please note that if there are differences between this policy letter and the HEDIS 1999 document, this OPL takes precedence for reporting data. The final HEDIS 1999 Volume 2: Technical Specifications is available from NCQA. Please call NCQA Publications at 1-800-839-6487 to obtain a copy. Download periodic corrections to Volume 2 from the NCQA web site: www.ncqa.org/hedis/h99cor.htm .

Contact: HCFA Regional Office Managed Care Staff

This OPL was prepared by the Center for Health Plans and Providers

PROGRAM REQUIREMENTS

1999 Contract year	Sampling Frame/ Period	Dates for Participation Eligibility	Minimum Sample Size	Market Area Reporting	Financial Responsibility	Demon-strations	Mergers and Acquisitions	Cost Contract Reporting	Due Dates
HEDIS 1999 and HEDIS 1999 audit	Services delivered in 1998 (and earlier for some measures)	First Medicare Enrollment on 1/1/98 or earlier (i.e. plans with initial Medicare enrollment on 2/1/98 or later are exempt.)	Measure specific (MCOs must report all Medicare measures according to instructions)	Yes	MCO pays for external HEDIS Audit	Yes, as specified at section I.C.10 below	Reporting by acquiring MCO (reporting of effectiveness of care measures only for nonsurvivor)	Report Cost Contract Measures	MCO must submit Audited Summary and Patient-Level Data by June 30, 1999.
Health Outcomes Survey	Members continuously enrolled 6 months prior to administration of survey	Medicare contract in place no later than 1/1/98; PACE demos with contract as of 1/1/99	1000 (If less than 1000 enrollees, all members must be surveyed.)	Yes	MCO pays for vendor to administer survey	Yes (See section I.C.10)	Reporting of surviving MCO's membership only	Yes	MCO must arrange to administer survey in March 1999.
CAHPS	Members continuously enrolled 6 months prior to administration of survey	Medicare contract in place no later than 7/1/98	600 (If less than 600 enrollees, all members will be surveyed.)	Yes	HCFA pays for survey administration	Yes (See section I.C.10)	Reporting of surviving MCO's membership only	Yes	HCFA will administer survey in Fall 1999.

IMPLEMENTING HEDIS 1999 MEASURES AND MEDICARE CAHPS

I. Specifics Applicable to CAHPS and HEDIS

A. Effects of the Balanced Budget Act of 1997

The Balanced Budget Act of 1997 established Part C of Medicare, known as the Medicare+Choice (M+C) program which will replace the current program of risk and cost contracting generally starting with contracts effective beginning January 1, 1999. The reporting requirements contained in this OPL apply to organizations that held Section 1876 risk or cost contracts during the calendar year of 1998 AND that either signed a contract to be a M+C organization in 1999 or that have a continuing contract under section 1876 as a cost-contracting entity. Please see section C below for exceptions to this requirement, such as organizations that have terminated their section 1876 contract with HCFA for 1999 or have reduced their service areas for 1999. Reporting authority pertaining to organizations contracting under the M+C program is found at 42 CFR 422.152.

B. M+C MCOs or Continuing Cost Contractors

1. Reporting Requirements

a. HEDIS 1999: A MCO must report HEDIS 1999 measures for their Medicare managed care contract(s), as detailed in the *HEDIS 1999 Volume 2: Technical Specifications* if:

- the contract was in effect on 1/1/98 or earlier;
- the contract had initial enrollment on 1/1/98 or earlier;
- the contract has been continued for the service area or a successor M+C contract has been obtained.

In other words, MCOs with a contract effective date of January 1, 1998 or earlier but with no initial enrollment on 1/1/98 or before do not have to participate in HEDIS reporting in 1999. The Medicare relevant measures in HEDIS 1999 that M+C MCOs must report are listed in Attachment I, and the Medicare relevant measures in HEDIS 1999 that continuing cost contractors must report are listed in attachment I.A.

b. Health Outcomes Survey: All M+C MCOs and continuing cost contractors that had a Medicare contract in effect on or before January 1, 1998, must comply with the HOS requirements during 1999.

Program of All Inclusive Care to the Elderly (PACE) plans approved by HCFA on or before March 1, 1999 must participate in the Health Outcomes Survey.

c. **Medicare CAHPS**: All M+C MCOs and continuing cost contracts that had a Medicare contract in effect on or before July 1, 1998, must comply with the CAHPS survey requirements during 1999.

Medicare CAHPS does not apply to M+C MCOs that received a contract effective after July 1, 1998. However, such MCOs may be required to undertake an enrollee satisfaction survey during 1999 to comply with the HCFA regulations on physician incentive plans (Vol. 61, Federal Register, 13430, March 27, 1996). Plans may wish to use Medicare CAHPS for this purpose.

2. **No Minimum Size Requirement:** There is no minimum size requirement for MCOs to report HEDIS 1999 measures or participate in the HOS and Medicare CAHPS surveys. When an MCO has fewer beneficiaries enrolled than the CAHPS sample size of 600 or the HOS sample size of 1,000, the entire membership must be surveyed.

An MCO must report all Medicare HEDIS measures, even if the MCO has small numbers for the denominator of a measure. Specific Guidelines for Effectiveness of Care Measures, Access/Availability of Care Measures, and Use of Services Measures in the *HEDIS 1999 Volume 2, Technical Specifications* (Pages 3, 33, 127, and183) discuss NCQA's new requirement on reporting for small numbers. For audited measures, a determination of rate suppression due to small sample numbers, *e.g.* "NA", will be made by the MCO's HEDIS auditor. For those measures not being audited, appropriate suppression for small denominators will be handled through the data submission process.

3. **Sampling and Reporting Unit: The "contract-market" is the reporting unit for HEDIS, CAHPS, and HOS and implies either reporting by contract or by a market area within a contract.** MCO's must report once for each contract unless HCFA divides the contract service area into "market areas." When the contract service area is subdivided, the resulting market areas cover more than one major community or city and each market area has at least 5,000 Medicare enrollees. In these situations, MCOs will report two or more sets of data for a given contract. This approach will provide more meaningful information to beneficiaries, plans, and HCFA. There are no exceptions to reporting by market area where applicable.

HCFA will assess all contract service areas to determine whether the HMO must report by market area. HCFA will notify plans whether they must report by market area and will identify the geography of each market area. MCOs that are not notified of market area reporting will report by contract.

Attachment I identifies the HEDIS 1999 measures by the level of reporting for each required measure: legal entity, contract, or market area (if applicable).

C. M+C Plans with Special Circumstances

1. **MCOs with Multiple Contracts: A MCO cannot combine small contracts or designated market areas into a larger reporting unit.** An MCO with multiple Medicare contracts must report

HEDIS 1999, CAHPS, and HOS surveys for each section 1876 risk and cost contract held in 1998. HCFA will notify plans as soon as possible whether they must report by market area.

2. **MCOs Carrying Cost or HCPP Members**: HEDIS performance measures will be calculated using only the Medicare enrollment in the section 1876 contract in effect at year end 1998. Therefore, the following beneficiaries should not be included in HEDIS calculations.

(1) any residual cost-based enrollees of a section 1876 risk contract
(2) any residual HCPP enrollees of a section 1876 cost contract

For HEDIS measures with a continuous enrollment requirement and for enrollees who converted from one type of contract to another (with the same organization), enrollment time under the prior contract will not be counted.

The CAHPS and HOS surveys will not include these cost members remaining from prior contracts.

3. **MCOs with New Members "Aging-in" from Their Commercial Product**: MCOs with members "aging into" their Medicare product from their commercial product must consider those members eligible for performance measure calculations assuming that they meet any continuous enrollment requirements. That is, plan members that switch from a MCO's commercial product to the MCO's Medicare product are considered continuously enrolled. Please see pg. 14 of *HEDIS 1999 Volume 2: Technical Specifications* for a discussion of "age-ins" and continuous enrollment requirements.

4. **MCOs with Changes in Service Areas**: MCOs that received approval for a service area expansion during the 1998 contract year and those that will be reducing their service area effective January 1, 1999 must include information regarding those beneficiaries in the expanding or reducing areas based on the continuous enrollment requirement and use of service provisions of the particular measure being reported.

5. **HMOs with Home and Host Plans**: The home plan must report the data related to services received by its members when out of the plan's service area. As part of the Visitor Program/Affiliate Option (portability), the host plan is treated as another health care provider under the home plan's contract with HCFA. The home plan is responsible for assuring that the host plan fulfills the home plan's obligations. Plan members that alternate between an MCO's visitor plan and the home plan are considered continuously enrolled.

6. **New Contractors**: MCOs with initial enrollment on February 1, 1998 or later will not report HEDIS 1999 performance measures for calendar year (CY)1998. However, these plans must have systems in place to collect performance measure information so that they can provide reliable and valid HEDIS data in 2000.

7. **Non-renewing/Terminating MCOs**: Entities that meet the HEDIS reporting requirements stated above but who have terminated their section 1876 contracts effective December 31, 1998

and have not signed a successor contract for that contract service area under the M+C program will not be required to submit HEDIS data in 1999 for CY 1998 or participate in the HOS or CAHPS survey.

8. **MCOs with Continuing Section 1876 Cost Contracts:** For cost contracts, HCFA has modified the HEDIS measures to be reported. Cost contractors will not report the Use of Services inpatient measures. The measures to be reported are listed on Attachment I.A. HCFA does not require cost contractors to report inpatient (e.g., hospitals, SNFs) measures because MCOs with cost-based contracts are not always responsible for coverage of the inpatient stays of their members. Cost members can choose to obtain care outside of the plan without authorization from the MCO. Thus, HCFA and the public would not know to what degree the data for these measures are complete.

Cost contracts will provide patient-level data for all the HEDIS Effectiveness of Care and the Use of Services measures for which they submit summary level data. (See Attachment I.A and III.)

9. **Mergers and Acquisitions:** HCFA has determined that the entity surviving a merger or acquisition shall report both summary and patient-level HEDIS data only for the Effectiveness of Care (EOC) measures listed in Attachment I, except the Medicare Health Outcomes Study, related to the former members of the non-surviving contract(s) [i.e., those contract(s) which have been terminated due to the merger]. This reporting by the surviving entity shall apply if the non-surviving contract was in effect for any part of 1998. Members of the non-surviving contract(s) will not be surveyed under CAHPS and HOS.

The purpose of reporting the six EOC measures for non-surviving contracts is to provide a more complete data base for HCFA and other researchers to explore issues of national interest. However, HCFA will not post this information for plan-to-plan comparisons since the contracts are no longer in effect and thus are not available for beneficiary selection. We recognize that beneficiaries and affiliated providers may be associated with the surviving entity's contract. However, HCFA believes that HEDIS measures based on the combined 1998 membership and providers of both contracts could be misleading since the management, systems, and quality improvement interventions related to the non-surviving contract are no longer in place. Reported results based on combined contracts may not reflect the quality of care or medical management available under the surviving contract.

The surviving contract(s) must comply with all aspects of this OPL for all members it had in 1998.

10. **Demonstration Projects:** HCFA also requires many demonstrations with section 1876 contracts or similar contracts to meet the HEDIS, CAHPS or HOS reporting requirements. Some demonstrations may not be subject to all requirements; the reporting requirements for each demonstration type are listed in the chart below. Demonstrations should discuss any modifications to the requirements in this OPL with their HCFA project officer. Other demonstration projects not identified here do not have to report HEDIS, CAHPS or HOS.

Demonstration	HEDIS 1999	HEDIS Audit	CAHPS	HOS
Social HMOs	Yes	Yes	Yes	Yes
Medicare Choices	Yes	Yes	Yes	Yes
Minnesota LTC	Yes	No	No	No
Evercare	Yes	No	No	Yes
PACE	No	No	No	Yes

D. Implications for Failure to Comply

HCFA expects full compliance with the requirements of this OPL. MCOs must meet the time lines, provide the required data, and give assurances that the data are accurate. Plans which do not comply may be subject to sanctions as provided for under BBA in section 1857(g) and in regulations at 422.752(b).

E. Use of Data

Data reported to HCFA under this requirement will be used in a variety of ways. The primary audience for the HEDIS, CAHPS, and HOS summary data is the Medicare beneficiary. These data will provide comparative information on contracts to beneficiaries to assist them in choosing among contracts. In addition, HCFA expects MCOs to use the data for internal quality improvement. Each MCO's summary HEDIS 1999 and Medicare CAHPS data will be arrayed and returned to them. The data should help MCOs identify some of the areas where their quality improvement efforts need to be targeted. Further, the data will provide HCFA and Peer Review Organizations with information useful for monitoring the quality of, and access to, care provided by MCOs. HCFA may target areas that warrant further review based on the data.

II. HEDIS 1999 Requirements

A. Summary and Patient-Level Data

HCFA is committed to assuring the validity of the summary data collected, before it is released to the public, and to make the data available in a timely manner for beneficiary information. **MCOs must submit HEDIS 1999 summary measures after completing the partial NCQA HEDIS Compliance Audit™ required by Medicare by June 30, 1999. MCOs must submit HEDIS patient-level data by June 30, 1999.** HCFA is requiring the submission of patient-level data on the same date as summary data to ensure that the patient-level data matches the summary data. In 1998, several MCOs discovered discrepancies between their patient-level and summary data after submitting their HEDIS 3.0/98 summary data.

Please note that auditors will review patient-level data for the numera